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F 000	INITIAL COMMENTS The following citation represents the findings of Complaint Investigation #80731.	F 000		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This Requirement is not met as evidenced by: The facility had a census of 49 residents. The sample included 3 residents. Based on observation, interview and record review the facility failed to thoroughly investigate falls, initiate appropriate interventions to identify and prevent future falls, and follow facility policy for follow up assessment after falls, by a licensed nurse, for 3 of 3 residents reviewed. (#1, #2, #3) Findings included: - Resident #1's quarterly (MDS) Minimum Data Set assessment, dated 9/21/14, identified the resident with severely impaired cognition, required extensive assistance of 2 staff with bed mobility, transfer, walking in room, and toileting, extensive assistance of 1 staff for dressing and hygiene, and a restorative program training in these areas. The resident was frequently incontinent of urine, occasionally incontinent of bowel, and participated in a toileting program. He/she was unable to regain balance without staff assistance.	F 323		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 323	Continued From page 1 The annual MDS assessment, dated 4/13/14, identified the resident with severely impaired cognition, required extensive assistance with his/her (ADLs) Activities of Daily Living. The MDS indicated the resident ' s balance was not steady, he/she required assistance to balance him/herself, was frequently incontinent of urine. The MDS indicated the resident had 2 falls with no injury and 1 fall with minor injury, and was on a restorative nursing program. The 4/17/14 Cognitive Loss (CAA) Care Area Assessment revealed the resident had Dementia and poor memory recall. The 4/17/14 Falls CAA revealed the resident fell 4 times, had impaired balance, transferred with a gait belt and 1 staff. The CAA stated the resident had periods of falling asleep at the dining room table and during conversations, and would get up without assistance. The 4/22/14 care plan directed staff to transport the resident in a wheelchair, with foot pedals, outside the room. On 6/19/14 the care plan staff assistance changed from 1 staff assistance to 2 staff with transfers and walking. The 9/30/14 care plan stated the resident was not to be left alone on the toilet, to place the resident in bed while in his/her room, and directed staff to not leave the resident alone in the wheelchair at any time. The care plan lacked direction to staff when the resident sat in a standard dining room chair. The 9/18/14 Fall Risk Assessment revealed the resident was a high risk for falls with a total score of 16, a score great than 10 was a high risk for falls. The 10/23/14 at 8:45 PM, the nurse's note	F 323		

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described the resident as lethargic with fatigue, he/she responded to verbal commands, with an elevated blood pressure and heart rate (values not stated).

The 10/25/14 at 8:00 AM, the nurse's note described the resident seated in the dining room, very lethargic, hardly opened his/her eyes, and required a lot of assistance with eating.

The 10/26/14 (not timed), urinalysis report revealed the resident urine contained E-Coli bacteria.

The 10/26/14 at 10:00 AM, the nurse's note revealed the physician was notified of the positive urinalysis result. At 7:22 PM, the physician order Cipro (antibiotic medication) 250 (mg) milligrams, twice a day, for 10 days.

The 10/27/14 at 10:00 AM, the nurse's note stated a Nurse Aide reported to the Nurse the resident was droopy, not his/her usual self, with a blood pressure of 183/93 and pulse of 93.

The 10/27/14 at 11:15 AM, the Fall Risk Assessment revealed the staff found the resident on the floor next to the dining room chair. Staff had the resident transported to the Emergency Room.

The 10/27/14 11:50 AM, the nurse's note revealed the resident seated in a dining room chair at a table. Approximately 5 minutes prior to the fall, staff observed the resident leaning in the chair and repositioned him/her, although staff was not present in the dining room at the time of the incident. The resident was found on his/her side next to the chair. He/she sustained a 3 by 3 centimeter laceration to the left side of his/her

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forehead. Emergency medical staff transported the resident to the Emergency Room.

The 11/1/14 at 2:00 PM, the Fall Risk Assessment Form revealed the staff found the resident beside the bed, the ADL worksheet was not followed by the staff member. The medical record lacked an entry in the Interdisciplinary Progress Notes describing the incident.

On 11/19/14 at 12:45 PM observation revealed nurse aides C and D preparing to transfer Resident #1 in the sit to stand lift. The resident was groggy, drooping his/her head. Staff cued the resident to place his/her hands on the grab bar on the lift multiple times, physically assisting the resident to place his/her hands. The resident hands dropped off the grab bar as the staff moved the resident via lift into the bathroom, at which time the resident became more alert.

On 11/19/14 at 3:03 PM, Nurse Aide E stated the resident confused and attempted to stand on his/her own from the bed and wheelchair. The care plan directed staff to not leave the resident alone in the wheelchair or the bathroom, but explained the resident routinely sat in the dining room chair for meals. He/she stated staff had not received directions addressing the resident sitting at the dining room table.

On 11/25/14 at 1:52 PM, Nurse F stated the resident was left alone and unattended in the dining room. He/she found the resident on the floor partially seated in the dining room chair, which had tipped over. He/she stated prior to the fall, the resident had pushed him/herself back in the chair, away from the table.

On 11/25/14 at 4:23 PM, Nurse B verified the

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charge nurse should have recognized the resident ' s change in condition and implemented appropriate interventions. He/she acknowledged the resident was also a fall risk when seated in a standard chair.

The facility ' s February 2009, Fall Prevention and Management Program stated the nurse must complete the facility's Fall Assessment, Fall Interventions forms, and make changes to the plan of care and ADL worksheet. The charge nurse should take immediate action to decrease or prevent future falls and revise the care plan.

The facility failed to establish and follow a care plan for Resident #1 after staff completed the MDS and CAA, with appropriate interventions that reflected the resident's inability to stabilize balance, had periods of falling asleep at the dining room table and during conversations, and would get up without assistance. The resident had a fall from a dining room chair, after being left unattended in the dining room area.

- Resident #2's annual (MDS) Minimum Data Set assessment, dated 9/28/14, identified the resident as cognitively intact, and independent with (ADLs) Activities of Daily Living, not on a toileting program, and occasionally incontinent of urine. The MDS indicated the resident's balance was not stable, although he/she could stabilize his/herself, experienced moderate pain affecting his/her physical functioning, had no falls, and received psychotropic medications.

The 10/3/14 ADL (CAA) Care Area Assessment stated the resident's 9/25/14 Tinetti test balance score was 10 out of 16, a high risk for falls. The CAA indicated the resident walked independently with a walker, requested staff assistance when

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F 323	Continued From page 5 unsteady, and required some assistance with ADLs. The 10/3/14 Urinary /incontinence CAA stated the resident toileted him/herself, received a daily diuretic medication (to rid the body of excess fluid), occasionally incontinent of urine and had a diagnosis of Overactive Bladder (leakage of large amounts of urine at unexpected times). The 10/3/14 Falls CAA stated the resident had no falls, experienced chronic pain, received narcotic pain medications, and a high risk for falls. The 7/15/14 care plan stated the resident walked independently with a walker, wore gripper socks at night, and the mattress on his/her bed was secured to the bedframe. The care plan instructed staff to provide assistance with walking as needed, and stated he/she was independent with toileting. The care plan reviewed on 10/3/14 and 11/19/14, with no fall intervention changes made. The 9/29/14 at 5:25 PM, nurse's note stated the resident reported he/she had the walker, washed his/her hands, turned and fell back over the walker. Two staff assisted the resident to stand up. The 10/2/14 at 12:00 PM, Fall Assessment form stated the resident fell when responding to a bladder urge, he/she had glasses on, but no footwear, the call light was on the bed, and the staff last observed the resident sleeping at 11:15 AM. The nurse sent a faxed request to the physician asking for permission for the resident to walk without his/her oxygen on to lessen the weight of the oxygen tank during walking. The 10/2/14 at 5:05 AM, the nurse's note stated	F 323		

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the staff found the resident on the floor by the bathroom, initiated neurological assessments, and notified the family and physician.

The 10/2/14 at 12:30 PM, Fall Assessment form, stated the resident fell in his/her room and was assisted by non-staff, he/she had glasses and shoes on, the resident was last seen toileting, staff directed the resident to call for help before getting up.

The 10/7/14 at 12:50 AM, nurse's note stated the resident requested 2 staff assist with a gait belt to walk him/her to lunch.

Review of laboratory results revealed urinalysis sample collected on 10/9/14 was hazy, with negative nitrates, and many bacteria and a urinalysis test on 10/22/14 and 10/30/14 were contaminated.

The 10/15/14 at 9:05 AM, nurse's note stated the resident complained of emptying his/her bladder. A pre bladder scan revealed 751 milliliters in the bladder and 522 milliliters post scan. The staff received a physician telephone order for Bactrim Double Strength twice a day for 5 days for the resident.

The 10/18/14 (not timed), nurse's note stated the resident complained of bilateral leg numbness at lunch.

The 10/19/14 at 6:00 PM, nurse's note stated the resident reported to the nurse that he/she had fallen, and stated his/her right knee gave out, and he/she sat in a chair to rest.

The 10/20/14 at 6:00 PM, the nurse's note stated the staff heard the resident yelling for help. The

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staff found the resident sitting on the floor between the bed and the air conditioning unit. The resident stood up with assistance from 2 staff and staff initiated neurological assessments.

The 10/20/14 at 8:35 AM, Fall Assessment form stated the resident fell in his/her room, he/she had glasses and white shoes on, and the call light was not within his/her reach. Interventions listed on the Post Fall Intervention form included adequate lighting, nonslip footwear, personal care items in reach, bed in low position, and bed positioned to allow resident to exit with stronger side if his/her body.

The 11/9/14 at 3:35 PM, nurse's note stated the resident fell and staff found him/her sitting on the floor in front of the bed, with his/her feet forward. The resident stated his/he reached for an object on the night stand and slid off the bed. Staff completed neurological assessments.

The 11/14/14 at 12:10 PM, the nurse's note stated he/she observed the resident ' s legs shaking uncontrollably and documented the resident had an elevated blood pressure (not documented) and experienced increased confusion. The note revealed the staff notified the physician of the resident's condition at 12:30 PM and the family at 1:10 PM. The note indicated at 12:50 PM the resident's confusion increased.

The 11/16/14 at 7:40 AM, nurse's note stated the staff found the resident lying on the floor parallel to the bed, and he/she stated his/her legs gave out.

The 11/16 /14 at 7:40 AM, Fall Assessment form stated staff found the resident lying on the floor with the oxygen tubing under his/her body, gripper

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socks on. The staff last observed the resident in the bathroom at 7:30 AM. The Post Fall Intervention form stated the nurse asked the physician for an order to straight catheterize the resident.

The 11/16/14 at 11:30 AM, nurse's note stated the staff walked the resident, with a gait belt and walker to lunch.

The 11/20/14 (untimed), nurse's note, late entry for 11/16/14, stated the nurse requested an order for a urinalysis (urine test), because the previous 2 urine test results stated the samples were contaminated.

On 11/25/14 at 11:57 AM, observation revealed Activity Staff G accompanied the resident with use of a walker. Staff G held the back of the resident's shirt as he/she walked across the hallway, then upon the staff's cue, the resident turned and sat in a chair.

On 11/19/14 at 3:35 PM, Resident #2 talked in reference to a recent fall, but could not be specific about the date and time. The resident explained he/she had a dizzy spell and his/her arms and knees gave out. The resident stated he/she turned on the call light and a nursing staff member informed the resident to go ahead and walk back on his/her own and left the bathroom. The resident stated he/she began to walk back into the room and fell.

On 11/19/14 at 5:24 PM, Nurse I stated the resident fell last weekend and used his/her emergency light in the bathroom. Nurse I entered the bathroom, and found the resident on the floor. Nurse I stated the resident had occasional confusion and had complained about the large

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size of the oxygen tank hanging on the walker.

On 11/25/14 at 1:43 PM, Nurse Aide H stated the resident has occasional confusion. Nurse Aide H stressed to the resident to leave the oxygen cannula (nose piece) on his/her face. Nurse Aide H stated the resident removes the oxygen tubing, becomes dizzy at times, and has a hard time walking, as his/her legs give out.

On 11/25/14 at 4:35 PM, Nurse B verified the nurses failed to implement an intervention after each fall to prevent future falls.

The facility's February 2009, Fall Prevention and Management Program stated the nurse must complete the facility's Fall Assessment Form and the Fall Interventions forms. The charge nurse will make changes to the plan of care and provide follow up assessment.

The facility failed to conduct a root cause analysis including the implementation of interventions after Resident #2's numerous falls, to prevent future falls.

- Resident #3's quarterly (MDS) Minimum Data Set assessment, dated 9/14/14, revealed the resident had moderately impaired cognition, walked independently in his/her room, required limited assistance with walking in the hallway and toileting. The MDS indicated the resident had unsteady balance, could regain his/her balance without assistance, received a diuretic medication (to rid the body of excess fluid), and participated in a restorative program for transfer and walking.

The 4/10/14 Cognitive Loss (CAA) Care Area Assessment identified the resident with poor memory recall and was hard of hearing.

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The (ADLs) Activities of Daily Living CAA, dated 4/10/14, stated the resident needed stand by assistance, and used a walker. The CAA indicated the resident scored 3 out of 16 for balance on the 4/3/14 Tinetti balance test.

The Falls CAA, dated 4/10/14, stated the resident had no falls, walked independently with a walker, received stand by assist, and had poor balance.

The 9/23/14 care plan stated the resident walked independently with 1 staff stand by assistance and a wheeled walker outside of his/her room. The care plan instructed staff to ensure the resident wore gripper socks at night and indicated the resident was at risk for falls with the use of Enalapril (blood pressure medication). The care plan did not address the resident's current urinary tract infection.

The 9/7/14 (not timed), Fall Risk Assessment described the resident as ambulatory and incontinent, had a balance problem with walking and a jerking motion with turns, and required a walker.

The 9/11/14 Tinetti test balance score was 8 out of 16. And a gait score of 6 out of 12, with a total score of 14/28 indicating a risk for falls. The resident required 1 staff assistance for walking with a walker for further distances, could transfer and safely walk in his/her room, using a walker, at a modified independent level.

The 10/19/14 urinalysis test revealed bacteria in the resident's urine.

The 10/22/14 physician's telephone order directed the staff to administer Bactrim Double

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Strength, by mouth, twice a day, for seven days to the resident, for a urinary tract infection.

The 10/23/14 at 3:30 PM, nurse's note revealed the resident had a low blood pressure at 86/56, when rechecked at 3:40 PM was 100/64.

The 10/24/14 at 2:50 PM, nurse's note revealed the resident's pulse in the mid 40's, and when staff rechecked his/her pulse it was 48, and the resident was lethargic.

The 10/25/14 at 11:10 AM, Vital Sign Record revealed a blood pressure of 88/62 and at 2:15 PM a blood pressure of 88/61. Review of the medical record for October and November revealed the resident's blood pressure averaged from 90-99/47-69.

The 10/26/14 at 6:30 AM, nurse's note stated the resident reported he/she fell on the bathroom floor, but did not remember what happened. The resident's injuries included a 3 (cm) centimeter bruise to the right hand, an 8 by 2 cm reddened area to the left shoulder, a 6 by 4 cm reddened area to the left breast, and a 5 by 5 cm reddened area to the right arm.

The 10/26/14 at 6:30 AM, Fall Assessment form revealed the resident reported a fall in the bathroom, did not remember if he/she stood from the floor on his/her own, details of the fall were recorded as unknown. Interventions stated for the fall included non-slip footwear, spills cleaned immediately, rule out pain issues, and assessment of transfer and transfer devices. (An assessment for transfer and devices could not be located).

The 10/27/14 at 2:20 PM, nurse's note stated the

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resident was lethargic, ate 0-5% of meals for the last 3 days, walked with 1 staff assist and use of a gait belt, and aroused to loud stimuli. The note stated the staff notified the physician of the resident ' s status.

The 10/28/14 restorative aide entry stated the resident refused therapy, due to weakness. The aide reported the resident's status to the nurse.

The 11/14/14 at 4:00 PM, nurse's note stated staff found the resident on the floor with his/her head against the closet, and legs toward the recliner. The note revealed the resident complained of head pain, stated he/she was walking back from the bathroom, and fell. The staff assisted the resident off the floor with a gait belt, into a chair.

The 11/14/14 at 4:00 PM, Fall Assessment form revealed the resident had on non-skid shoes, glasses, the call light was within reach, and he/she fell walking back from the bathroom. Interventions implemented included checking the tips of the walker for non-skid covers, assessing the resident for steadiness, rule/out pain issues, and assessment of transfer and the transfer device. (An assessment for transfer and devices could not be located).

On 11/19/14 at 3:20 PM, observation revealed Nurse Aide G provided stand by assistance for the resident to stand and walk. The resident attempted to stand 2 times, sat back down on the chair and was able to stand on the 3rd attempt. Observation revealed the resident stood for a minute, walked slowly with hesitation between steps, and with his/her right foot turned inward with each step

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E181	A. BUILDING _____ B. WING _____	C 12/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CITIZENS MEDICAL CENTER LTCU	1625 S FRANKLIN AVE COLBY, KS 67701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 13 On 11/25/14 at 12:37 PM, Nurse Aide H stated the resident does not use the call light to request assistance, although the staff placed the call light within the resident's reach and frequently remind him/her to use the call light. Nurse Aide H stated the resident becomes weak when walking and has to rest before reaching his/her destination, and verified staff had not changed the care plan to prevent future falls. On 11/25/14 at 2:01 PM, Nurse I stated the resident has impaired cognition, becomes weak when walking and sits down to rest. Nurse I stated the resident does not use the call light for assistance when he/she gets up and is a fall risk. On 11/25/14 at 4:26 PM, Administrative Nurse B acknowledged the transfer assessments were not completed and verified the nurse completing the fall assessment would make a care plan change after a fall to prevent further fall, and no changes were made to the care plan to address falls. The facility's February 2009, Fall Prevention and Management Program stated the nurse must complete the facility's Fall Assessment Form and the Fall Interventions forms. The charge nurse will make changes to the plan of care and ADL worksheet. For care plan revision, the charge nurse should take immediate action to decrease or prevent future falls. The facility failed to reevaluate, including effectiveness of current interventions for falls and need for further interventions, for Resident #3, who had several falls.	F 323		